Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

EMPLOYERS INSURANCE OF WAUSAU MUTUAL CO

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-06-0107-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not pay claim at the usual + customary. Hospital is requesting we be reimbursed at usual + customary."

Amount in Dispute: $7,025.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Renaissance Hospital Denied entire bill x170 – preauthorization was required but not requested for this service per TWCC Rule 134.600. Renaissance Hospital was not the authorized provider. It is noted that the provider did not send a copy of the pre-certification letter with the appeal. Texas Surgicom has also billed as the facility for these injections."

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 17, 2005	Outpatient Services	$7,025.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that

specific fee guidelines are established by the commission."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §134.600 sets out the requirements and procedures for preauthorization of specified health care.
5. 28 Texas Administrative Code §133.1 provides definitions of words and terms related to medical benefits.
6. This request for medical fee dispute resolution was received by the Division on August 29, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 15, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - X170 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER TWCC RULE 134.600. (X170)
   - Z585 – THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z5585)
   - Z346 – RIGHT SIDE. (Z346)

Findings

1. The insurance carrier denied disputed services with reason code X170 – "PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER TWCC RULE 134.600." 28 Texas Administrative Code §134.600(b), effective March 14, 2004, Volume 29 *Texas Register*, page 2349, states, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care…" 28 Texas Administrative Code §133.1(a)(7)(A), effective July 15, 2000, 25 TexReg 2115; defines an emergency as "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part." 28 Texas Administrative Code §134.600(h)(2), effective January 1, 2003, Volume 27 *Texas Register*, page 12359; states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Review of the documentation submitted by the requestor finds that the requestor has not submitted documentation to support a medical emergency as defined in 28 Texas Administrative Code §133.1. Nor did the requestor present documentation to support preauthorization as required under §134.600(h). This denial code is therefore supported.
2. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282,

applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor did not submit a position statement for consideration in this dispute.
- The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "Carrier did not pay claim at the usual + customary. Hospital is requesting we be reimbursed at usual + customary."
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not explain how payment of its usual and customary charges would result in a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment in the amount of its usual and customary charges would result in a fair and reasonable reimbursement for the services in dispute.
- The request for reconsideration letter to the insurance carrier states that the requestor "…relies upon a portion of the Adopted Medical Fee Guidelines 1996…" adopted by reference in former Division rule at 28 Texas Administrative Code §134.201, Volume 21 *Texas Register* page 2361. However, the 1996 Medical Fee Guideline is not applicable to the services in dispute, as indicated in former Division rule at 28 Texas Administrative Code §134.401(a)(4), effective August 1, 1997, Volume 22 *Texas Register* page 6264, which states that "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." 28 Texas Administrative Code §134.1 is the applicable rule for determining reimbursement for the services in this dispute.
- The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

	Grayson Richardson	May 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.